

STATE OF ILLINOIS

Page 2

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER# 0027342 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>20</u>	Skilled (SNF)	<u>20</u>	<u>7,320</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>54</u>	Intermediate (ICF)	<u>54</u>	<u>19,764</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>74</u>	TOTALS	<u>74</u>	<u>27,084</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>670</u>		<u>691</u>	<u>1,361</u>	8
9	SNF/PED					9
10	ICF	<u>12,919</u>	<u>9,874</u>		<u>22,793</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>13,589</u>	<u>9,874</u>	<u>691</u>	<u>24,154</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 89.18%

D. How many bed-hold days during this year were paid by Public Aid?

8 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)NONEF. Does the facility maintain a daily midnight census? YESG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 03/01/70

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number
of beds certified 20 and days of care provided 691Medicare Intermediary ADMINASTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/04 Fiscal Year: _____

* All facilities other than governmental must report on the accrual basis.

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Facility Name & ID Number CANTERBURY MANOR NURSING CENTI # 0027342 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	117,193	7,074	6,083	130,350		130,350		130,350		1
2	Food Purchase		80,936		80,936	4,251	85,187	(347)	84,840		2
3	Housekeeping	61,166	10,721		71,887	182	72,069		72,069		3
4	Laundry	54,933	7,953		62,886		62,886		62,886		4
5	Heat and Other Utilities			68,840	68,840	523	69,363		69,363		5
6	Maintenance	26,250	15,130	25,013	66,393		66,393		66,393		6
7	Other (specify):*										7
8	TOTAL General Services	259,542	121,814	99,936	481,292	4,956	486,248	(347)	485,901		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	846,868	23,342	64,560	934,770	(3,326)	931,444		931,444		10
10a	Therapy	2,515		2,475	4,990		4,990		4,990		10a
11	Activities	40,696	5,080	1,340	47,116	(2,379)	44,737	(255)	44,482		11
12	Social Services	32,122		1,340	33,462		33,462		33,462		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	922,201	28,422	69,715	1,020,338	(5,705)	1,014,633	(255)	1,014,378		16
	C. General Administration										
17	Administrative	55,912			55,912	70,286	126,198		126,198		17
18	Directors Fees										18
19	Professional Services			210,558	210,558	(115,631)	94,927	(88,773)	6,154		19
20	Dues, Fees, Subscriptions & Promotions			7,274	7,274	200	7,474	(3,816)	3,658		20
21	Clerical & General Office Expenses	24,883	5,648	5,459	35,990	18,140	54,130	(528)	53,602		21
22	Employee Benefits & Payroll Taxes			171,267	171,267	14,295	185,562		185,562		22
23	Inservice Training & Education			98	98		98		98		23
24	Travel and Seminar			3,039	3,039	224	3,263		3,263		24
25	Other Admin. Staff Transportation					1,986	1,986		1,986		25
26	Insurance-Prop.Liab.Malpractice			41,742	41,742	2,160	43,902		43,902		26
27	Other (specify):*										27
28	TOTAL General Administration	80,795	5,648	439,437	525,880	(8,340)	517,540	(93,117)	424,423		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,262,538	155,884	609,088	2,027,510	(9,089)	2,018,421	(93,719)	1,924,702		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

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Facility Name & ID Number **CANTERBURY MANOR NURSING CENTER** #0027342 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			22,571	22,571	2,446	25,017	38,813	63,830			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,053	2,053		2,053	(556)	1,497			32
33	Real Estate Taxes					783	783	20,780	21,563			33
34	Rent-Facility & Grounds			354,000	354,000	5,860	359,860	(354,000)	5,860			34
35	Rent-Equipment & Vehicles			192	192		192		192			35
36	Other (specify):*											36
37	TOTAL Ownership			378,816	378,816	9,089	387,905	(294,963)	92,942			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		44,506	56,678	101,184		101,184		101,184			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			40,626	40,626		40,626		40,626			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		44,506	97,304	141,810		141,810		141,810			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,262,538	200,390	1,085,208	2,548,136		2,548,136	(388,682)	2,159,454			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER

0027342

Report Period Beginning:

01/01/2004

Ending:

12/31/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	19,409	30		9
10	Interest and Other Investment Income	(45,155)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(347)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(12)	21		18
19	Entertainment				19
20	Contributions	(516)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(3,604)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(412)	20		28
29	Other-Attach Schedule	(55)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (30,692)		\$	30

OHF USE ONLY						
48		49		50		51
						52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	(357,990)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (357,990)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (388,682)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

STATE OF ILLINOIS
CANTERBURY MANOR NURSING CENTER

Page 5A

ID# 0027342
Report Period Beginning: 01/01/2004
Ending: 12/31/2004

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	PICK UP ONE YEAR OF TWO YEAR	\$	1
2	IDPH LICENSE PAID IN 2003 FOR 2003 AND	200	20
3	2004		
4	ELIMINATE ACTIVITY EXPENSE PER	(255)	11
5	INCOME RECEIVED		
6			
7			
8			
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48			
49	Total	(55)	

STATE OF ILLINOIS

Summary A

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER

0027342

Report Period Beginning:

01/01/2004

Ending:

12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(347)	0	0	0	0	0	0	0	0	0	0	(347)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(347)	0	0	0	0	0	0	0	0	0	0	(347)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(255)	0	0	0	0	0	0	0	0	0	0	(255)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(255)	0	0	0	0	0	0	0	0	0	0	(255)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(88,773)	0	0	0	0	0	0	0	0	0	(88,773)	19
20	Fees, Subscriptions & Promotions	(3,816)	0	0	0	0	0	0	0	0	0	0	(3,816)	20
21	Clerical & General Office Expenses	(528)	0	0	0	0	0	0	0	0	0	0	(528)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(4,344)	(88,773)	0	0	0	0	0	0	0	0	0	(93,117)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(4,946)	(88,773)	0	0	0	0	0	0	0	0	0	(93,719)	29

Summary B

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
LIST ATTACHED		SENIOR MANOR NURSING CENTER	SPARTA	Jamestown mgmt	Carbondale	Management
		FAIR ACRES NURSHING HOME	DUQUOIN	Corp		
		FAIRVIEW NURSING CENTER	DUQUOIN			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	19 MANAGEMENT FEES	\$ 204,761	JAMESTOWN MANAGEMENT CORPORATION	10.00%	\$ 115,988	\$ (88,773)
2	V	33 REAL ESTATE TAXES		WATERLOO LAND TRUST	100.00%	20,780	20,780
3	V	34 RENT	354,000	WATERLOO LAND TRUST	100.00%		(354,000)
4	V	32 INTEREST EXPENSE		WATERLOO LAND TRUST	100.00%	44,732	44,732
5	V	30 DEPRECIATION		WATERLOO LAND TRUST	100.00%	19,404	19,404
6	V	32 INTEREST INCOME		WATERLOO LAND TRUST	100.00%	(133)	(133)
7	V						
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$ 558,761			\$ 200,771	\$ * (357,990)

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CANTERBURY MANOR NURSING CENT # 0027342 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
1	OWNER'S COMPENSATION HAS BEEN ELIMINATED PRIOR TO THE COST REPORT.					Hours	Percent	Description	Amount		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER # 0027342 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Jamestown Management Corporation
 Street Address 1001 E. Main Bldg 4a
 City / State / Zip Code Carbondale, IL 62901
 Phone Number (618) 549-8331
 Fax Number (618) 549-0133

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	HOURS OF SERVICE	16,655	\$ 6,090	\$	3,697	\$ 1,352	1
2	5	UTILITIES	HOURS OF SERVICE	16,655	2,357		3,697	523	2
3	17	ADMINISTRATIVE	HOURS OF SERVICE	11,093	316,560	316,560	2,463	70,286	3
4	19	LEGAL & ACCOUNTING	HOURS OF SERVICE	16,655	1,609		3,697	357	4
5	20	LICENSES & DUES	HOURS OF SERVICE	16,655	900		3,697	200	5
6	21	CLERICAL SALARIES	HOURS OF SERVICE	5,562	67,833	67,833	1,235	15,062	6
7	21	CLERICAL & GEN OFFICE EX	HOURS OF SERVICE	16,655	11,228		3,697	2,492	7
8	22	PAYROLL TAXES	HOURS OF SERVICE	16,655	55,218		3,697	12,257	8
9	24	SEMINARS	HOURS OF SERVICE	11,093	1,008		2,463	224	9
10	25	AUTO EXPENSE	HOURS OF SERVICE	11,093	8,946		2,463	1,986	10
11	26	GENERAL INSURANCE	HOURS OF SERVICE	16,655	9,731		3,697	2,160	11
12	30	DEPRECIATION	HOURS OF SERVICE	16,655	11,018		3,697	2,446	12
13	33	REAL ESTATE TAXES	HOURS OF SERVICE	16,655	3,529		3,697	783	13
14	34	RENT	HOURS OF SERVICE	16,655	26,400		3,697	5,860	14
15									15
16									16
17									17
18			**EXCESS SALARY OF RELATED INDIVIDUAL HAS BEEN ELIMINATED PRIOR TO COST REPR						18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 522,427	\$ 384,393		\$ 115,988	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Canterbury Manor Nursing	x		1st Mortgage	\$4,741.00	07/20/00	\$ 565,000	\$ 490,341	7/20/25	0.0900	\$ 44,732	1	
2	Center											2	
3												3	
4												4	
5												5	
	Working Capital												
6	Banterra Bank		x	Revolving line of credit						0.0625	2,053	6	
7				for operating funds								7	
8												8	
9	TOTAL Facility Related				\$4,741.00		\$ 565,000	\$ 490,341			\$ 46,785	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 565,000	\$ 490,341			\$ 46,785	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **CANTERBURY MANOR NURSING CENTER**# **0027342** Report Period Beginning: **01/01/2004** Ending: **12/31/2004****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2003 report.		\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$ 20,780	2
3. Under or (over) accrual (line 2 minus line 1).		\$ 20,780	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 20,780	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1999 15,009	8	
	2000 18,418	9	
	2001 20,341	10	
	2002 20,538	11	
	2003 20,780	12	
***Line 7 does not include the Jamestown allocation from page 8 schVIII of \$783. Real estate taxes of page 4 line 33 should reconcile to line 7 \$20780 + Jamestown \$783 = 21563.			
		13	FROM R. E. TAX STATEMENT FOR 2003 \$ 13
		14	PLUS APPEAL COST FROM LINE 5 \$ 14
		15	LESS REFUND FROM LINE 6 \$ 15
		16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME CANTERBURY MANOR NURSING CENTER COUNTY MONROE

FACILITY IDPH LICENSE NUMBER 0027342

CONTACT PERSON REGARDING THIS REPORT Roger W. Bagley

TELEPHONE (618) 549-8331 FAX #: (618) 549-0133

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>07-24-250-031-000</u>	<u>N. Market Street part lot 1 sur 640</u>	\$ <u>1,758.16</u>	\$ <u>1,758.16</u>
2. <u>07-24-250-026-000</u>	<u>718 N. Market Street Tax Lot 6 BA</u>	\$ <u>19,021.86</u>	\$ <u>19,021.86</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>20,780.02</u></u>	\$ <u><u>20,780.02</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES x NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 16,374

B. General Construction Type: Exterior masonry Frame

Number of Stories

C. Does the Operating Entity?
 ☐ (a) Own the Facility
 ☒ (b) Rent from a Related Organization.
 ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?
 ☐ (a) Own the Equipment
 ☒ (b) Rent equipment from a Related Organization.
 ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 ☐ YES
 ☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Original bldg & addition	50,000	1970-75	\$ 25,823	1
2	Additional land	22,597	1995	108,977	2
3	TOTALS	72,597		\$ 134,800	3

STATE OF ILLINOIS

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Facility Name & ID Number CANTERBURY MANOR NURSING CENTER

0027342

Report Period Beginning:

01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	60		1970	1970	\$ 123,000	\$	30	\$		\$ 123,000	4
5	14		1976	1976	80,226		25			80,226	5
6			1970	1970	49,513		25			49,513	6
7			1976	1976	866		10			866	7
8			1976	1976	10,413		15			10,413	8
	Improvement Type**										
9	VARIOUS/FULLY DEPRECIATED			1970	14,327		various			14,327	9
10	REMODELING			1974	565		25			565	10
11	NURSES CALL SYSTEM			1976	7,457		15			7,457	11
12	NURSES STATION			1976	30,851		20			30,851	12
13	SPRINKLER & SMOKE DETECTOR			1976	34,295		25			34,295	13
14	REMODELING			1977	6,714		15-20			6,714	14
15	LAND IMPROVEMENTS			1980	900		15			900	15
16	LAND & GUTTERING			1981	7,199		15			7,199	16
17	ROOF REPAIR & ACTIVITY ROOM			1986	30,422		15			30,422	17
18	PARKING LOT			1987	1,670		7			1,670	18
19	GAS LINE			1989	1,637		15	56	56	1,637	19
20	VARIOUS IMPROVEMENTS			1990	13,962	931	15	931		13,499	20
21	CABINETS & FLOORING			1994	2,461	164	15	164		1,723	21
22	VARIOUS IMPROVEMENTS			1994	21,632	1,442	15	1,442		15,141	22
23	ROOF REPAIR			1995	2,565	171	15	171		1,625	23
24	WATER HEATER			1995	3,000		15	200	200	1,900	24
25	FIRE ALARM			1995	7,207		15	480	480	4,560	25
26	TELEPHONE SYSTEM			1995	713		20	36	36	342	26
27	CARPETING			1996	2,423		7			2,423	27
28	RENOVATING ROOMS			1996	4,403	440	10	440		3,740	28
29	REPLACED WATER HEATER			1996	550		15	37	37	314	29
30	REPAIR SHOWER			1996	2,244	224	10	224		1,904	30
31	LANDSCAPING			1996	973	97	10	97		825	31
32	REPLACE WATER HEATER			1996	680		15	45	45	383	32
33	Labor/materials to remove existing and install new waterproof			1997	4,009	401	10	401		3,007	33
34	wallcovering and floor tile										34
35	Labor/materials to remove and install new cabinets/countertops			1997	6,853	685	10	685		5,138	35
36	in nurses station										36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	REPAIR PLUMBING	1997	\$ 4,010	\$ 267	15	\$ 267		\$ 2,003		37
38	REPAIR GROUNDWATER DRAIN	1997	790	53	15	53		397		38
39	PREP AND SEAL PARKING LOT	1997	1,145		5			1,145		39
40	SIGN	1997	531		5			531		40
41	OVERBED LIGHTING	1998	8,636	864	15	576	(288)	3,744		41
42	FLOORTILE AND CARPETING	1998	10,612	1,516	15	707	(809)	4,596		42
43	LANDSCAPING	1998	4,817	482	10	482		3,133		43
44	Labor/materials to remove entry way, rebuild walls, paint	1998	11,907	1,191	15	794	(397)	5,161		44
45	& replaace elec serv in DON, Socserv, breakroom. Move wall									45
46	expand kitchen. Created storage area by relocating doors									46
47	Trims, pictures, mirrors & other permanent fixtures to	1998	3,025	49	5		(49)	3,025		47
48	refurbish the remodeled building									48
49	PARKING LOT	1998	56,963		15	3,798	3,798	24,687		49
50	WATER SOFTNER	1998	1,400		10	140	140	910		50
51	FIRE SUPPRESSION SYSTEM	1998	1,356		10	136	136	884		51
52	GAZEBO	1999	4,084		20	204	204	1,122		52
53	COURTYARD AWNINGS	1999	850		5	85	85	850		53
54	INSTALL 911 ALARM SYSTEM	1999	519	86	5	51	(35)	519		54
55	LANDSCAPING AND SIDEWALKS	1999	2,189	219	10	219		1,204		55
56	WINDOWS FOR FRONT OF BUILDING	1999	2,658	266	10	266		1,463		56
57	LANDSCAPING OF COURTYARD	1999	466	47	10	47		258		57
58	WALLPAPERING	1999	218	35	5	20	(15)	218		58
59	BUILDING ADDITION	2000	411,559		15	27,437	27,437	123,467		59
60	ADJUSTMENT TO 1999 DPA COST REPORT	2000	(173)							60
61	BUILDING ADDITION	2000	17,651		15	1,177	1,177	5,296		61
62	DOOR ALARM SYSTEM	2000	5,996		10	600	600	2,700		62
63	Labor/materials to install new cabinets/countertops, relocae	2000	1,346		10	135	135	607		63
64	heating, electrical services, and lighting in the breakroom									64
65	EXTENSION & MODEM JACK INSTALLED IN NEW OFFICE	2000	1,071		10	107	107	482		65
66	Labor/materials to remove existing wall and relocate wall	2000	9,093	838	10	909	71	4,091		66
67	to expand nurses station and install new cabinetry &									67
68	countertops, lighting, and electrical services									68
69										69
70	TOTAL (lines 4 thru 69)		\$ 1,036,449	\$ 10,468		\$ 43,619	\$ 33,151	\$ 649,072		70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 1,036,449	\$ 10,468		\$ 43,619	\$ 33,151	\$ 649,072	1
2	INSTALL TILE FLOORING IN EAST WING	2000	6,858	632	15	457	(175)	2,057	2
3	CABINETS INSTALLED IN 6 MED ROOMS	2000	5,789	534	15	386	(148)	1,737	3
4	Labor and materials to remove existing cabinetr and sinks	2000	2,845	262	15	190	(72)	855	4
5	and install new cabinets/sinks, replace plumbing and								5
6	electrical on east wing								6
7	ABSTRACT WATER FOUNTAIN IN COURTYARD	2000	1,155	103	5	231	128	1,040	7
8	FRUIT URN FOUNTAIN IN DRIVE	2000	945	84	5	189	105	851	8
9	LANDSCAPING	2000	1,519	140	10	152	12	684	9
10	ELEVATED EAST WING FLOOR/WALLS OF BUILDING	2001	3,875	258	15	258		903	10
11	Replaced employee door, new frame, door, and hardware	2001	2,129	213	10	213		745	11
12	Code modifications to fire sprinkler system	2001	2,566	257	10	257		899	12
13	Installation & replacement of aluminum patio door system	2001	4,223	422	10	422		1,477	13
14	Replace pressure switch and repair lines in fire sprinkler sys	2002	5,790	579	10	579		1,448	14
15	SEAL AND STRIPE PARKING LOT	2002	3,440	688	5	688		1,720	15
16	Relocate 2 water meters to meet city codes	2002	1,700	113	15	113		283	16
17	REPLACED WATER HEATER	2003	3,539	867	10	354	(513)	531	17
18	REPLACED WATER SOFTNER	2003	1,913	468	10	191	(277)	287	18
19	INSTALLED WIRING FOR CABLE TV INSTALLATION	2003	2,898	927	10	290	(637)	435	19
20	Demolition and reconstruction of wall, relocate door, and	2003	6,155	616	10	616		924	20
21	install electrical service for laundry								21
22	Replace flooring in south hall bathroom	2004	2,039	102	10	102		102	22
23	Replaced fixtures and cabinets in soiled utility room. Repaired	2004	2,083	104	10	104		104	23
24	walls and doors and painted.								24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,097,910	\$ 17,837		\$ 49,411	\$ 31,574	\$ 666,154	34

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 105,043	\$ 3,697	\$ 11,431	\$ 7,734	variable	\$ 70,015	71
72	Current Year Purchases	7,259	1,037	542	(495)	variable	542	72
73	Fully Depreciated Assets	168,869				variable	168,869	73
74								74
75	TOTALS	\$ 281,171	\$ 4,734	\$ 11,973	\$ 7,239		\$ 239,426	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	JAMESTOWN ALLOCATION			\$	\$ 2,446	\$ 2,446	\$		\$ 23,699	76
77										77
78										78
79										79
80	TOTALS			\$	\$ 2,446	\$ 2,446	\$		\$ 23,699	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,513,881	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 25,017	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 63,830	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 38,813	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 929,279	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$		86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 192 Description: storage 171; carpet cleaner 21

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2005 \$ _____

13. /2006 \$ _____

14. /2007 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary. We only hire trained aides.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39/39/2	hrs	\$	279	\$ 17,765	\$ 270	279	\$ 18,035	1
2	Licensed Speech and Language Development Therapist	39/3	hrs		56	5,139		56	5,139	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39/3	hrs		373	27,552		373	27,552	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39/2	# of prescrpts				29,230		29,230	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10			hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
	oxygen, tube feeding, medical supplies	39/2								
13	Other (specify): lab, xray, ambulance	39/3				6,222	15,006		21,228	13
14	TOTAL			\$	708	\$ 56,678	\$ 44,506	708	\$ 101,184	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 22,660	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	322,503		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	22,511		5
6	Prepaid Insurance	4,140		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 371,814	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	224,076		15
16	Equipment, at Historical Cost	214,533		16
17	Accumulated Depreciation (book methods)	(355,764)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Loan to Waterloo Land Trust</u>	490,341		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 573,186	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 945,000	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 33,772	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	36,313		30
31	Accrued Taxes Payable (excluding real estate taxes)	15,330		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>401k Liability</u>	13,726		36
37	<u>Banterra Bank Line of Credit</u>	13,334		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 112,475	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 112,475	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 832,525	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 945,000	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 792,801	1
2	Restatements (describe):		2
3	Federal tax refund received 2002 & 2003	12,396	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 805,197	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	27,328	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 27,328	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 832,525	24 *

* This must agree with page 17, line 47.

STATE OF ILLINOIS

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Facility Name & ID Number CANTERBURY MANOR NURSING CENTER # 0027342 Report Period Beginning: 01/01/2004

Ending: 12/31/2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 2,386,864	1
2	Discounts and Allowances for all Levels	12,424	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,399,288	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	94,540	6
7	Oxygen	16,626	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 111,166	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	2,078	19
20	Radiology and X-Ray	1,475	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 3,553	23
	D. Non-Operating Revenue		
24	Contributions	16,302	24
25	Interest and Other Investment Income***	45,155	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 61,457	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,575,464	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	481,292	31
32	Health Care	1,020,338	32
33	General Administration	525,880	33
	B. Capital Expense		
34	Ownership	378,816	34
	C. Ancillary Expense		
35	Special Cost Centers	101,184	35
36	Provider Participation Fee	40,626	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,548,136	40
41	Income before Income Taxes (line 30 minus line 40)**	27,328	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 27,328	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? no If not, please attach a reconciliation. IL taxes are deducted c federal tax return

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

STATE OF ILLINOIS

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Facility Name & ID Number CANTERBURY MANOR NURSING CENTER# 0027342Report Period Beginning: 01/01/2004Ending: 12/31/2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,312	1,552	\$ 40,256	\$ 25.94	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,196	3,419	63,857	18.68	3
4	Licensed Practical Nurses	13,407	14,421	248,987	17.27	4
5	Nurse Aides & Orderlies	43,041	46,203	485,175	10.50	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	223	239	2,515	10.52	8
9	Activity Director	3,379	3,643	40,696	11.17	9
10	Activity Assistants					10
11	Social Service Workers	1,740	2,077	32,122	15.47	11
12	Dietician					12
13	Food Service Supervisor	1,933	2,142	31,434	14.68	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,606	10,130	85,759	8.47	15
16	Dishwashers					16
17	Maintenance Workers	2,045	2,192	26,250	11.98	17
18	Housekeepers	6,948	7,641	61,166	8.00	18
19	Laundry	5,913	6,276	54,933	8.75	19
20	Administrator	1,880	2,080	55,912	26.88	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,062	2,194	24,883	11.34	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>ward clerk</u>	923	1,026	8,593	8.38	33
34	TOTAL (lines 1 - 33)	97,608	105,235	\$ 1,262,538 *	\$ 12.00	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	125	\$ 6,083	1/3	35
36	Medical Director			9/3	36
37	Medical Records Consultant		1,068	10/3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		550	10/3	39
40	Physical Therapy Consultant	42	2,367	10A/3	40
41	Occupational Therapy Consultant	2	108	10A/3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant			10A/3	43
44	Activity Consultant	42	1,340	11/3	44
45	Social Service Consultant	42	1,340	12/3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	253	\$ 12,856		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	8	\$ 320	L10/C3	50
51	Licensed Practical Nurses	363	13,177	L10/C3	51
52	Nurse Aides	2,567	49,445	L10/C3	52
53	TOTAL (lines 50 - 52)	2,938	\$ 62,942		53

A. Administrative Salaries				Ownership		D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%	Amount	Description	Amount	Description	Amount			
JOHNNY LAW	ADMINISTRATOR	0	\$ 55,912	Workers' Compensation Insurance	\$ 32,244	IDPH License Fee	\$ 200			
				Unemployment Compensation Insurance	11,673	Advertising: Employee Recruitment	130			
				FICA Taxes	96,584	Health Care Worker Background Check				
				Employee Health Insurance	11,749	(Indicate # of checks performed 16)	262			
				Employee Meals	2,038	CLIA (150) NAGNA (1898)	2,048			
				Illinois Municipal Retirement Fund (IMRF)*		SUBSCR (355) CORP FEES (463)	818			
				401k EMPLOYER MATCHING FUNDS	12,700	OTHER ADVERTISING	4,016			
				LIF INSURANCE	96	JAMESTOWN ALLOCATION	200			
				AWARDS, ATTENDANCE, PARTIES, ETC.	5,063					
				VACCINES	1,158					
				JAMESTOWN ALLOCATION	12,257					

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

[illegible]

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN, LPN, NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 7 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ N/A Line _____
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation. _____
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. _____
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 40,626
This amount is to be recorded on line 42 of Schedule V. _____
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation. _____
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions. _____
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 2,038 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? NONE
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees. _____

CANTERBURY MANOR NURSING CENTER #0023742
 RECLASSIFICATIONS ON DPA COST REPORT
 PAGES 3 & 4 COLUMN 5
 12/31/2004

LINE #	ACCOUNT TITLE	DEBIT	CREDIT
2	FOOD PURCHASES	3910	
10	NURSING & MEDICAL RECORDS		3910
	RECLASSIFY FOOD SUPPLEMENTS		
21	CLERICAL & GEN OFFICE EXPENSE	586	
10	NURSING & MEDICAL RECORDS		586
	RECLASSIFY OFFICE SUPPLIES		
10	NURSING & MEDICAL RECORDS	1170	
3	HOUSEKEEPING		1170
	RECLASSIFY SOAP & SHAMPOO		
2	FOOD PURCHASES	2379	
11	ACTIVITIES		2379
	RECLASSIFY FOOD USED IN ACTIVITIES		
22	EMPLOYEE BENEFITS	2038	
2	FOOD PURCHASES		2038
	RECLASSIFY EMPLOYEE MEALS		
VARIOUS	VARIOUS LINE ITEMS	115988	
19	PROFESSIONAL SERVICES		115988
	RECLASSIFY JAMESTOWN ALLOCATION		
	SEE SCHEDULE VIII FOR BREAKDOWN		